

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

1. PLACE OF DEATH

County Webster
Township West Dallas
City (No.)

Registration District No. 901Primary Registration District No. 6210

43241

File No. Registered No. 25St. Ward 2. FULL NAME Elizabeth Blau(a) Residence. No. St. Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U.S., if of foreign birth EC

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED

HUSBAND OF
(OR) WIFE OFFred Blau6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 18-7889

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1
day, hrs.
or min.93912

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of workHousekeeper(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

own home9. BIRTHPLACE (CITY OR TOWN) Tybing

(STATE OR COUNTRY)

Switzerland

10. NAME OF FATHER

Mathys11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Unknown

PARENTS

14.

INFORMANT

(Address)

Fred Blau Elizabeth Mathys
Fordland Mo

15.

FILED 2-30-1931Weller & Atkins

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 30 1931

17.

I HEREBY CERTIFY, That I attended deceased from

19 , to19 that I last saw h. alive on 19 , and thatdeath occurred, on the date stated above, at 12:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

no physician in attendance200AUnknown

(duration)

yrs.

mos.

ds.

CONTRIBUTORY

(SECONDARY)

Dr. J. J. J.

(duration)

yrs.

mos.

ds.

18. WHERE WAS DISEASE CONTRAICTED

IF NOT AT PLACE OF DEATH at place of deathDID AN OPERATION PRECEDE DEATH? noDATE OF WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed)

Fred Blau Sr.

Dec 30, 1931 (Address)

Fordland Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Int Olive Cem.Dec 31 1931

20. UNDERTAKER

ADDRESS

E. F. Starr. Fordland Mo

(Approved by U. S. Census and American Public Health Association.)

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENT
BY PHYSICIAN.

Every item of information should be carefully supplied. AGs should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Webster Registration District No. 901
Township West Dallas Primary Registration District No. 6210
City St. Louis (No. 1) St. 1 Ward 1

File No. 23
Registered No. 23

2. FULL NAME

(a) Residence, No. Elizabeth Dulan St. 1 Ward 1
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR/OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Wid
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar 18-1889
7. AGE YEARS 92 MONTHS 9 DAYS 12 If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19

19. UNDERTAKER (ADDRESS)

20. FILED Feb 11 1932 Nellie Atkins Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 30 19 31

22. I HEREBY CERTIFY, That I attended deceased from

to 19

I last saw him alive on 19 Death is said

to have occurred on the date stated above, at m.

The principal cause of death and related causes of importance were as follows:

Date of onset

Other contributory causes of importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) M. D.

(Address)

S-43241